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ABSTRACT

This paper contains testimony and prepared statements from the Congressional hearing called to examine ways of controlling cancer. Opening statements are included from Representatives Claudine Schneider, Jim Lightfoot, and Ben Blaz. Testimonies are given by Rosemarie Lindgren, a homemaker and former cancer patient, and by Jules Cardin, a patient representative of the Steering Committee of the Colorectal Health Check Task Force, who describes his successful battle against cancer of the colon in 1946 and his adjustment to having cancer and living with a colostomy. Also testifying are Frank Cummings of the Colorectal Health Check Task Force and Vincent Mor of the Center for Health Care Research at Brown University. Mor discusses a study he is conducting to explore the special needs of elderly cancer patients. Three representatives of the Rhode Island Department of Health provide testimonies: (1) H. Denman Scott, the director, discusses the most frequent types of cancer deaths (breast, lung, and intestinal/colon cancers), emphasizing preventive measures and modern techniques for screening and treatment; (2) Jay Buechner, Office of Data Evaluation, provides cancer statistics; and (3) Tricia Leddy, Office of Nutrition Services offers suggestions for dietary changes and nutrition. Witnesses stress the need to control diet, smoking, drinking, exposure to sun, and environmental pollution; and recommend regular check-ups, awareness of warning signs, and a positive attitude as methods of lowering the risk of cancer. (NRB)

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CONTROLLING CANCER: CHOICES FOR A HEALTHY LIFE

ED264475

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

JUNE 10, 1985, CRANSTON, RI

Printed for the use of the Select Committee on Aging

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CONTENTS

Members' Opening Statements

	Page
Claudine Schneider	1
Jim Lightfoot	3
Ben Blaz	4

Chronological List of Witnesses

Jules Cardin, member, Steering Committee of the Colorectal Health Check Task Force	5
H. Denman Scott, M.D., director, Rhode Island Department of Health	8
Jay Buechner, Ph.D., chief, Office of Data Evaluation, Rhode Island Department of Health	12
Tricia Leddy, chief, Office of Nutrition Services, Rhode Island Department of Health	20
Dr. Frank Cummings, Colorectal Health Check Task Force	22
Vincent Mor, Ph.D., director, Center for Health Care Research, Brown University	30
Rosemarie Lindgren, homemaker, Saunderstown, RI	37

CONTROLLING CANCER: CHOICES FOR A HEALTHY LIFE

MONDAY, JUNE 10, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Cranston, RI.

The committee met, pursuant to notice, at 1 p.m., at the Senior Citizen Center, 85 Rolfe Street, Cranston, RI, Hon. Claudine Schneider (acting chairperson of the committee) presiding.

Members present: Representatives Schneider of Rhode Island, Blaz of Guam, Lightfoot of Iowa.

Staff present: Anne Schwartz, legislative assistant and Arthur Lisi, staff assistant, of Representative Schneider's staff.

OPENING STATEMENT OF REPRESENTATIVE CLAUDINE SCHNEIDER

Mrs. SCHNEIDER. Could I have your attention, please? I would like to share with those of you who are here, this is probably your first congressional hearing and for your information, the way congressional hearings are run is that everything that is stated here today will be included in the record.

We have a court reporter here, who will take the testimony of witnesses from here, and it will be used in future hearings in Washington.

It is not often that we are able to bring committees to Rhode Island, but I have taken the opportunity to use my influence to bring two very important colleagues here today to join us in what I believe is probably one of the most critical issues that we can be dealing with.

We will be hearing from a number of expert witnesses, and there is no participation from the audience in this kind of congressional hearing. All of you have a chance to see me any time anyway at town meetings and whatever, but this is an official hearing.

Let me thank all of you for coming here today, and I would like to extend special thanks to the witnesses who have taken time out of their busy schedules to enlighthen us about the progress in controlling cancer, and to the staff of the Cranston Senior Center for allowing us to use this facility.

Before we begin, I would like to say a word about the House Select Committee on Aging which was created in 1974. It provides direction and insight on Federal policies affecting senior citizens, overseeing the activities of the various congressional committees which have jurisdiction over such areas as senior housing, health

care, and pensions. We are charged with three specific responsibilities.

First of all, our committee studies the unique problems confronting older Americans. We also have the responsibility of encouraging positive programs that will assist seniors to live full and active roles in our society, and third, the Select Committee on Aging is empowered to develop policies benefiting seniors which encourage coordination between the public and the private sectors.

We are responsible, as a committee, for informing the Congress, for overseeing the executive branch, and providing all of you with an opportunity to participate in the policymaking process. And since it is a very long way to Washington, I have brought the Aging Committee here to you.

Now, you will not only have a chance to hear about cancer prevention, but you will also see how this whole congressional process works.

Let me introduce to you my two colleagues on the Aging Committee who have joined us this afternoon, Congressman Jim Lightfoot and Congressman Ben Blaz. Congressman Lightfoot represents the southwest corner of the State of Iowa. This is his first term in Congress, and in addition to his work on the Aging Committee, he serves on the Public Works and Transportation Committee and the Government Operations Committee.

Congressman Blaz is also in his first term and he represents the Island of Guam, but I understand he has spent some time in Rhode Island before at our Newport Naval War College. He sits on the Armed Services Committee and the Interior Committee.

Welcome to you both.

Now, the matter before us today is a very serious one. We are discussing cancer. In 1985, about 910,000 people will be diagnosed as having cancer. About 462,000 people will die of cancer, or approximately 197 persons out of every 1,000. But in Rhode Island, the figures are even more staggering. It is estimated that there will be 4,900 new diagnoses and 2,500 cancer deaths in our State in 1985, which is a rate of 263 per thousand. Lung and colorectal cancers will account for nearly half of all Rhode Island cancer-related deaths.

While cancer can strike at any age, and I personally can attest to that because I was 25 years old when I first learned that I had Hodgkin's disease. A 25-year-old has 1 chance in 700 of developing cancer in the next 5 years, but a 65-year-old faces 1 chance in 14. Approximately 75 percent of all cancer deaths occur in individuals over the age of 60.

Now, these might be frightening facts to you, but there is great hope for the future and that is why I am here today and anxious to share with you some of the information from our witnesses.

In 1900, cancer was almost always fatal. However, today 43 percent of all cancers are considered curable. Mortality has declined 16 percent in breast cancer, 58 percent in Hodgkin's disease and 38 percent in other lymphomas. Continued progress, of course, will depend upon advances in medical science and technology, but part of the responsibility lies within each of us.

First of all, we can learn how to lower the risk of cancer. A number of studies have shown that the largest cancer factors are

the ones that we can control: diet, tobacco, alcohol use, exposure to sunshine and environmental pollution.

Second, we can beat cancer by fighting back early. The American Cancer Society estimates that 160,000 people will die this year who might have been saved by early diagnosis and treatment.

Regular checkups and awareness of cancer's early warning signals are a very good beginning, and finally, a positive attitude, courage, love, and lots of faith are the important elements that can also make the difference between life and death.

And, as I mentioned, many of you know this, that I myself have fought Hodgkin's disease, a form of cancer affecting the lymph system, and I have won, so that you have before you living proof that we can control cancer. You, too, can make the choice for a healthy life and the expert witnesses that we will have joining us this afternoon will let us know some of the specifics of how we can have better control over our health.

First, I would like to call on my colleagues for any comments they may have as introductory statements.

STATEMENT OF REPRESENTATIVE JIM LIGHTFOOT

Mr. LIGHTFOOT. Thank you.

Congressman Blaz, witnesses and members of the audience, it is a great pleasure to be here in Rhode Island today to hear testimony about controlling cancer, choices for a healthy life.

I think it is a timely hearing and one that will provide the Aging Committee and the general public with some very good information about cancer. It is a serious disease and it strikes fear into every American.

Almost every person in this room has been touched by cancer, either through personal experience or through an acquaintance, or through a loved one. Over 450,000 people in the United States die each year from the disease. Estimates indicate that 910,000 new cases of cancer will be detected this year, 1985.

Although cancer knows no age limit, the elderly suffer to a greater degree from it. A 25-year-old has 1 chance in 700 of developing cancer in the next 5 years, but a 65-year-old faces 1 chance in 14.

Approximately 50 percent of all newly diagnosed cancers and 60 percent of all deaths from the disease occur in that 11 percent of the population that is over the age of 65.

Cancer by many is seen as being the top killer by the year 2000. James Engstrom, who is a research professor at the UCLA School of Public Health, said that cancer will surpass heart attack type diseases at the turn of the century because cancer rates are increasing, while heart disease rates are decreasing.

Figures indicate that a person's chance of dying of cancer will increase 22 percent today to 26 percent at the turn of the century.

On the other hand, however, many researchers believe that progress is being made toward controlling cancer. Some remark about advances in prevention and treatment of the disease which has improved many people's outlook.

For example, in 1900, cancer was generally considered as being incurable. By 1930, about 25 percent of cancers were curable, large-

ly by surgery. With the advent of radiation and chemotherapy, 43 percent of cancers are considered curable today.

As Mrs. Schneider mentioned, she is living proof it can be done; it is being done. Significant advances are being made in cancer research, and we are also seeing more interest in preventing cancer and more awareness in detecting the early signs of cancer. These are all positive signs. However, much more can and should be done.

The witnesses we have here today should indicate to us that we have come a long way since those earlier years. We still have a long road to travel before we have controlled cancer and quieted the fears of millions of Americans.

Finally, I would like to thank Congresswoman Schneider for calling this hearing. She has shown us what a person can do when faced with cancer. She has fought a battle and she has won, and in the process, she has set a model for all of us to follow, and she is an inspiration to many of us in Congress.

We thank you folks for being here, and thank Claudine very much.

Mrs. SCHNEIDER. Thank you.

Congressman Blaz.

STATEMENT OF REPRESENTATIVE BEN BLAZ

Mr. BLAZ. Thank you Madam Chairman.

I want to say publicly how much I want to commend Claudine for the initiative and the foresight of having this hearing here today.

As she mentioned, I had the good fortune of being stationed here in Rhode Island on two occasions, and I must admit that I fell in love with the place very, very early in my career.

I must also admit that when she asked me to come, being from an island myself, I said, how can I refuse anybody asking me to return to Rhode Island? So, between us Islanders, we may well address some of our problems.

On a more serious note, I may say, since I am the only one in this delegation who appears to be closing in on the age that we all seem to have here, I am more concerned than they are about cancer.

Both my parents died of cancer and I am beginning to think that perhaps if they had had the benefit of a more positive attitude, of more encouragement from those who were so close to them, they might not have had to leave us earlier than they did.

So I have more than a passing interest, I have a personal interest, an interest in this State but above all, I think it is marvelous that we will have an opportunity to hear firsthand accounts so that when we get back in the sessions to discuss the problems of our committee and problems that face America, we will be able to say that we have heard the witnesses.

I commend you again, Claudine, and I am looking forward to the hearing.

Mrs. SCHNEIDER. Thank you very much.

Now, I would like to call forward our first two witnesses, Rosemarie Lindgren and Jules Cardin. Mr. Cardin is a retiree from Woonsocket who serves on the Steering Committee of the Colorec-

tal Health Check Task Force as the patient representative, and he has been very active, and for good reason, takes good pride in his community service in this area and he is going to give us a little bit of insight as to his own personal experiences.

Your entire testimony will be incorporated into the record so if you choose to summarize rather than reading, you have that option, too.

STATEMENT OF JULES CARDIN, MEMBER, STEERING COMMITTEE OF THE COLORECTAL HEALTH CHECK TASK FORCE

Mr. CARDIN. Thank you very much.

Thank you, Congresswoman Schneider, Congressman Blaz and Congressman Lightfoot. Ladies and gentlemen. Can you hear me all right?

I invite you to come with me on a trip back in time to an evening in November of 1946, almost 39 years ago. We find ourselves in a room on the fifth floor of the New England Deaconess Hospital in Boston.

A 28-year-old man sits alone, deep in thought. Two weeks earlier, he was told that he has a malignant cancer of the colon, quite advanced and the next morning must undergo surgery for removal of the cancer. The rest of his life must be lived with a colostomy, about which he knows nothing.

Here I will digress to explain what a colostomy is. Having to remove an extensive part of the colon and seal off the rectum, the surgeon must make provisions for the elimination of waste material from the body. So an opening is made in the abdomen and about two inches of bowel is drawn through that opening and sutured in place, thus allowing for elimination.

I leave to your imagination the mental adjustment that it takes to come to grips with this radical change in an ordinary bodily function which we all take for granted. That very morning, our man in the hospital room has said goodbye to his three daughters, 4 years, 2 years and 6 months old, had driven to Boston with his wife, and said goodbye to her that afternoon.

The surgeon had told him that he had a 25-percent chance of surviving the surgery, and if he did survive, what kind of life could he look forward to. Remember that he had been told nothing about life with a colostomy.

I am sure that you have guessed by now that the man in that hospital room was me. I want to assure you that I was, and still am, grateful to God for being alive.

Of course, I was also grateful for something else. The surgeon had told me that one of the probable side effects of this type of surgery would be impotence, thus my inability to father anymore children. You will remember that we had three daughters at the time and I am happy to tell you today that we had six more children since the surgery. And that my wife and I are the proud parents of eight girls and one boy. So much for side effects.

The survival rate for this type of cancer is still only one in four, even today, if detected late, and you will hear more from Dr. Cummings about this, but if detected early, the survival rate goes up to three in four.

Simple tests would change the odds of surviving from 25 percent to over 75 percent. Almost as important, late detection would mean that the lucky survivor would have a permanent colostomy after serious surgery.

Early detection would mean a simple procedure, after which the patient would return to a normal life. I am speaking to you today because I have experienced the feeling of being kicked by a mule, which hits you when the doctor must tell you at 28 years old, or at any age, that you have advanced colon cancer, must have surgery and have only a 25-percent chance of surviving.

Here you have my reason for eagerly joining the Cancer Society's task force. I am speaking from experience, having survived the onslaught of this dreaded enemy. For 1 year now, my friends on the task force and I have brought the message of early detection to nurses and staff in hospitals, and to the general public at club meetings and in the work place, and we intend to continue doing this whenever and wherever we are called upon, and if our efforts can reduce the mortality rate in Rhode Island by one, and can reduce the number of those having to live with an ostomy by one, then I will feel that I have expressed my gratitude to God for having placed his finger on me in that hospital so long ago, and granted me 39 more years of life.

Thank you very much.

Mrs. SCHNEIDER. Thank you very much. That was excellent testimony. Mr. Cardin, don't run away. We may have some questions for you.

Has Mrs. Lindgren arrived? No? OK. Well——

Mr. CARDIN. So we have some extra time.

Mrs. SCHNEIDER. There are some questions that my colleagues might like to ask, Mr. Cardin.

Mr. CARDIN. Certainly.

Mr. LIGHTFOOT. Mr. Cardin, what kind of advice could you give someone who has discovered that they are going to have to go through that kind of radical surgery? You have got such a positive attitude—today is a great day and tomorrow is going to be better.

Mr. CARDIN. I have to tell you, Congressman, that that attitude didn't develop right away. First of all, for the first 5 years, those are the dangerous years where the cancer can recur, so those years, everytime there is any kind of a little pain anywhere, you say, well, here we go again.

Once you get over that, then the only thing to do is go on living, and in my case, I have to be frank with you, I didn't have much time to worry about myself, because I told you, we had a sizeable family. So, actually, you just stop thinking about it. I mean you can't live on the edge all your life.

Same as the nuclear bomb now, we don't think about it every day, and you just go along and live. It is not easy. As the Congresswoman can tell you, I am sure, it is not easy, but you do what you have to do.

Mr. LIGHTFOOT. With the colostomy, and in your professional life, you had to make some adjustments that the rest of us didn't have to. I am sure there are some psychological problems involved with that. How do you deal with that?

Mr. CARDIN. There, again, it takes a long time to get over that, because when you regain your senses, after the operation you get home from the hospital, you get to feeling that you are not a whole person anymore, that you have changed.

So it does change your whole outlook, and here again, it takes a couple of years to come to grips with this. The mental attitude I was talking about, it takes a couple of years.

There are people today—I am active in the Woonsocket Chapter of the Cancer Society—we have a visitor's bureau, and there are people today that at any age—one young man I saw just last week, 38 years old, who become practically recluses. They can't handle it, and there they need professional help. But you just have to overcome it. What can you do? You can't lie down and say it is the end of the world.

Mr. LIGHTFOOT. Thank you for coming today. I am sure you are an example and inspiration and we appreciate it.

Mr. CARDIN. I appreciate your giving me the time.

Mrs. SCHNEIDER. Congressman Blaz.

Mr. BLAZ. I cannot resist the temptation to suggest that perhaps we ought to have the operation you had.

Mr. CARDIN. No, no.

Mr. BLAZ. I cannot believe you look so well. Anyway, let me ask you a more serious question, sir.

There has been some talk about the relationship between the same positive attitude that you speak about and the ability of a patient to recover and face this enormous personal challenge. Do you share that view that has crept up in the last few years?

Mr. CARDIN. Yes. As a matter of fact, that attitude existed back then, and exists now, the percentage of one survivor out of four. As it happens, at that particular time, I was operated on in Boston, I became acquainted with three other people in Woonsocket. One was a taxi driver, a woman, and another man, who had gone through this—and the three of them died within 6 months.

And one was a mill worker. And you are right, Congressman, a lot will depend on your particular attitude. Fortunately, I have always had an upbeat attitude.

Of course, that won't stop the cancer from recurring, but at least it will help you resume your normal life, establish a life.

You are right, and that does make a difference, too.

Mr. BLAZ. Thank you very much, sir.

Mrs. SCHNEIDER. I would like to interject, in my capacity, as a member of the Science and Technology Committee, that we have had hearings on the interrelationship of the physical, the mental, and the emotional, and how those three are so well correlated, and it is believed that part of the reason that there are such high incidences among seniors is emotional, that they feel there is no one that they need to care for.

You had to care for three children and that was part of the driving motivating force to stay alive. Oftentimes seniors feel that they may not have an important function, and so they feel, "Well, cancer, OK, I will die." There are statistics that prove that more often than not, it does more than allow you to get on with your life or have a positive attitude, but it really does help extend one's life above and beyond.

Now, what I am interested in finding out is that all too often doctors do have a tendency to tell you what your chances of survival are, and with all due respect to the doctors in the audience, you were told you had a 25-percent chance of survival?

Mr. CARDIN. Yes, one out of four.

Mrs. SCHNEIDER. And I was told that I had a 50–50 chance, and my attitude was, after I was completely depressed and saddened, that if my chances of survival were 50–50, I was going to be 51.

I just would like your opinion as to what you think. Do you think, as a counselor now to people who do have cancer, do you think that it is advisable for doctors to tell their patients what they think their chances of survival are, or do you think that is better left unsaid and let the patient determine that for himself?

Mr. CARDIN. No. In my opinion, Congresswoman, and I talked to quite a few people—as a matter of fact, I visit cancer patients before their surgery to encourage them, and my observation is that they should be told.

Mrs. SCHNEIDER. That they should be told what their chances are?

Mr. CARDIN. I will tell you why. Because the patient not knowing will think that his chances are one in a thousand. So, you know, one out of four, it ain't bad, really.

If I can have an other minute?

Mrs. SCHNEIDER. Yes.

Mr. CARDIN. Maybe I am off base, but I have got to put this in because Congressman Lightfoot brought up the question about motivation, and I think what I had on my side is I am a Canadian, brought up in this country, very, very strong Catholic faith, very strong, to the extent of never questioning.

That is how I was brought up. So when you got that kind of faith, and the doctor tells you that only one in four come out of this, you know that you are going to be the one, and it is that faith that keeps you going and that is why those with a great deal of faith have a big advantage over those who don't have any faith, or who don't pay any attention to it, because you do what you can and then you put the rest in the hands of God; you are finished, and that is how I lead my life.

Mrs. SCHNEIDER. Thank you very much. We appreciate your input. Now, I would like to call to the witness stand Dr. Denman Scott and Dr. Jay Buechner. Welcome.

Let me begin by introducing Dr. Scott. He is the director of the Rhode Island Department of Health since July 1984. He also serves as clinical associate professor of medicine at Brown University, and he was recently named the Governor-elect at the Rhode Island Chapter for the American College of Physicians and I would like to ask Dr. Scott to begin, please.

STATEMENT OF H. DENMAN SCOTT, M.D., DIRECTOR, RHODE ISLAND DEPARTMENT OF HEALTH

Dr. SCOTT. Thank you very much, Congresswoman Schneider, and other members of the panel. It is a treat to be here, and I certainly, as the director of health, applaud this opportunity to speak

on these issues, and to get a sense of your concern in the U.S. Congress.

I have a formal statement which I am not going to read, which will be happy news to most of you. I think a number of the points have already been very well made by you all in your opening statements.

There are several points I would like to highlight and go over with you all. First of all, I would like to say that prior to becoming director of the health department, I practiced internal medicine for almost a decade, and was responsible for the care of many elderly people. In the course of taking care of them. I became involved with many people afflicted by cancer.

I think that the way people are learning to deal with the disease we see the extraordinary strength and heroism and the lessening of fear in many circumstances. This is laudable. It is always tough and always puts you through a unique ringer of life, if you will. Now that we are able to talk about it more in public, it becomes easier for professionals—physicians, nurses and other health workers—to work with people who become afflicted. The testimony of Mr. Cardin was really a remarkable statement as to what can be accomplished.

Now, we are hearing about the incidence of the disease going up and up. To some degree this is true. But part of the explanation arises from the fact that we are living more and more. Why are we living more and more?

One reason is that the cardiovascular diseases are really dropping off at a phenomenal rate. For example, people dying from strokes or "shocks" have fallen since 1970, by over 40 percent.

Similarly, the death rate from heart attacks is over 20 percent lower than it was in 1970. It appears that this trend will continue.

It is not altogether clear why, this is happening. Part of the reason is healthier lifestyle; part of it is advances in medical care. Thus, we have more life to live, and thereby we have more opportunity to develop a cancer.

Thus, I don't want anybody to feel we are being engulfed by a cancer epidemic. If we all could live to be 200, I suspect every one of us would end up with a cancer of some sort.

I want to make a few comments about the big three, not to say all the others aren't important, because they are, but 60 percent of our deaths from cancer are caused by tumors of the breast, tumors of the lung, and tumors of the intestine and colon.

For in each of these tumors there is something we can do to prevent them or detect them at an early time, maneuvers which will augment our chance of survival. Let me make a brief comment about each of these.

First of all, the cancer of the lung could almost disappear—it wouldn't disappear but would almost—if cigarette smoking disappeared. It is as simple as that.

The cigarette is public enemy No. 1 to our health, not only in terms of cancer, but also cardiovascular disease. The message about the hazards of smoking is unbelievably persuasive.

In the case of breast cancer, we don't have such a clear idea of what causes it. However, we know with the modern techniques of mammography, which is an x-ray of the breast, that tumors can be

found well before they can be felt, at a time when the chances of it having spread to a distant site are markedly reduced. If we could persuade and expand our screening for breast cancer we could reduce the death rate from breast cancer markedly.

How much, I don't know. But I would suspect between 40 and 50 percent. As Congresswoman Schneider said, already breast cancer death has gone down by 16 percent, still the occurrence—new cases—of the disease is truly frightening.

When I was in medical school, I graduated in 1966, the professors told me then that 1 in 20 women would develop this disease. Now it is almost 1 in 11, so about 9 percent of women are destined to develop this.

There are some major psychological hurdles here. First because a mammogram exposes the breast to radiation, people became frightened that the x-ray itself would cause cancer. Indeed there has been a big debate among the medical profession about this. The debate has spilled over into the public consciousness, frightened many and kept them away from this kind of screening.

Current screening techniques are vastly safer than those used just 15 years ago. The second hurdle is the fear women have of losing a breast—a real deep concern for many.

Now there are more conservative surgical approaches available to many women. These techniques only remove the tumor and leave the breast largely intact. Thus, both safer mammography and the opportunity for simpler surgery should help us get more people evaluated and ultimately saved from this particular tumor.

Colon cancer is also a toughy. The simplest screening is to take a little sample of stool and test it for blood. If you find it you can then pursue a diagnostic evaluation, which is uncomfortable. I am sure many of you have had barium enemas and many of you have had these things called sigmoidoscopies. Nobody goes around advertising these as somethings they like doing. It is uniformly uncomfortable. Happily there are now some new instruments which give better visualization of the bowel which are much less painful.

The psychological distaste of the diagnostic procedure scare people away, and they even scare doctors away. I took care of a good number of doctors. A few said "no way, Jose".

We all have to get away from the "no way, Jose" syndrome. If we do, we can save, rather than one in four, we can save three in four. It all depends on early detection.

Well, let's talk a minute—am I going on too long?

Mrs. SCHNEIDER. You should start wrapping up your remarks.

Dr. SCOTT. One point about smoking. People do get the message, but they get it in a differential kind of way. If you have a rosy future, if you are financially well off, if you have an interesting life, you are much more willing to invest in the future by not smoking, as opposed to somebody who lives in grim circumstances, in proverty, and doesn't see a bright future.

In grim circumstances, people say why not smoke. If we question well-off people, we see they do smoke less, and if we question people in rough circumstances, they smoke more. So, the opportunity to win the smoking battle is linked with the challenge to reduce further poverty and ignorance in the society.

In 1964 when the first Surgeon General's report on smoking came out, roughly 40 percent smoked. By 1983 only 8 percent smoke. The challenge now is to convince the public about not smoking as doctors have convinced themselves.

With that, let me close.

[The prepared statement of Dr. Scott follows:]

PREPARED STATEMENT OF H. DENMAN SCOOT, M.D., DIRECTOR OF HEALTH, RHODE ISLAND DEPARTMENT OF HEALTH

Representative Schneider, Members of the U.S. House of Representatives Select Committee on Aging, and fellow Rhode Islanders: I greatly appreciate the opportunity to address the Select Committee on Aging on this issue of great urgency. As the Director of Health in Rhode Island it is my responsibility to seek ways to address the goals of protecting our population from exposure to disease risk factors and assuring that adequate health services are available to the sick and disabled. The disease of cancer demands our attention from both of these perspectives. It is my responsibility to bring sobering situations to the attention of the public. I have no choice when the topic is cancer.

The great personal fear we feel when we hear about cancer striking a family member or friend is certainly justified: Today, the chances one will get cancer during a lifetime are 35 percent; in the year 2000 the chances will increase to 41 percent. By the year 2000 cancer will become the country's number one cause of death and the number one killer of the elderly, overtaking heart disease. It was recently reported that the number of new cancer cases is now rising at the rate of a little over one percent each year, and the death rate is increasing by nearly half a percent each year. I find these statistics staggering.

In Rhode Island, our problem is particularly severe. We have the highest rate of cancer mortality among the states, even when adjusted for our age distribution, and the second highest proportion of elderly after Florida. As cancer is primarily a disease of the elderly, this means an elevated number of cancer deaths in Rhode Island. Two-thirds of cancer deaths in Rhode Island are of persons age 65 and older. Ninety percent are persons age 55 and older. Cancer mortality rates for those age 65–74 are four times the average for all ages. If this cannot be called a cancer epidemic now, it most certainly will be called a cancer epidemic early in the next century as we experience the inevitable aging of the "baby boom" generation—and if we allow these trends to continue.

From my perspective as Director of Health I accept the challenge of working to reduce untimely death and improve quality of life by altering these disturbing trends.

To date, the emphasis in the effort to alter those trends has been on treatment. While continued research into treatment techniques cannot be abandoned, it is time to commit our resources to public health efforts in the areas of prevention and early detection. We know that the pattern of cancer incidence has varied widely across national boundaries and within subgroups of the population. Only a small fraction of cancer incidence can be explained by hereditary factors. We now know a substantial amount about other causes of cancer. We now know that 80 percent of cancers are believed to be caused by personal risk factors—factors such as smoking, dietary patterns, alcohol consumption and exposure to the sun. More than 80 percent of all lung cancers and up to 50 percent of all bladder cancers could be prevented if people stopped smoking. Skin cancer is largely preventable through avoidance of excessive exposure to the sun.

Secretary of Health and Human Services Margaret Heckler recently got to the heart of the matter. She urged Americans to accept the "simple truth that cancer is usually caused by the way we live". Tobacco is known to cause 30 percent of all cancer deaths. Diet is known to cause an additional 35 percent of all cancer deaths. Mrs. Heckler stated that changes in diet and smoking habits alone could reduce cancer deaths by 25 percent by the year 2000, and could save 95,000 lives a year.

The theme, therefore, of any public health effort aimed at reducing cancer rates should be that cancer is a largely preventable disease. Because of what we now know about the causes of cancer, it will be through prevention and early detection efforts that cancer will be combated. Historically, most major epidemics have been conquered by prevention, not treatment, and cancer is a preventable disease.

I have said that there is little glamour in prevention. It carries none of the excitement or intensity of managing a patient in shock from overwhelming infection or of by-passing clogged coronary arteries. Yet, as a society we celebrate the successes

brought by major health prevention efforts. We head into slippery terriroty when we ask people to modify habits long associated with pleasure—such as smoking or drinking alcohol. We human beings have been slow to respond to the convincing evidence that a variety of personal practices will adversely affect our health. A Department of Health and Human Services survey showed that 49 percent of the American people don't know what they can do to prevent cancer and 46 percent say they think "there is not much a person can do". Individuals have difficulty applying general health risk factors to their own situations. Younger individuals have difficulty accepting the possibility that current behavior can impact future risk.

Cancer prevention from the public health perspective means educating the population regarding healthy lifestyles. It is imperative that Rhode Islanders, and all Americans, be educated to understand that we can control our risk of getting cancer through a personal healthy lifestyle—consuming alcohol in moderation, increasing our intake of fiber and reducing our intake of fat, quitting smoking, and avoiding over-exposure to the sun. It should also be recognized that a healthy lifestyle relative to cancer is very similar to a healthy lifestyle relative to heart disease, stroke, diabetes, and cirrhosis of the liver—other major killers of the elderly.

Public health efforts on the cancer front must focus on directing resources into prevention and early detection from the Federal level down to the local level. Local prevention efforts can be tailored to meet local needs based on the timely and effective use of available local data. Public health resources must be distributed to keep people well for as long as possible and to relieve the suffering imposed by disease thereby improving the quality of life.

I will close by reiterating that 80 percent of all cancers are caused by personal risk factors. I join Margaret Heckler in urging all Rhode Islanders and Americans to work with those of us committed to improving the public's health by recognizing that cancer is usually caused by the way we live. It is time to put our resources into prevention—because cancer is a preventable disease.

I thank you for the opportunity to address you today.

Mrs. SCHNEIDER. Thank you very much.

We would like to hear now from Dr. Jay Buechner, who is the chief at the Office of Data Evaluation, Rhode Island Department of Health. He was also senior research associate at Rhode Island Health Services Research from 1980 to 1983 where he directed the Rhode Island Cancer Information Center and analyzed statewide cancer incidence and mortality data, and we welcome you here this afternoon to share with us some of that data.

STATEMENT OF JAY BUECHNER, PH.D., CHIEF, OFFICE OF DATA EVALUATION, RHODE ISLAND DEPARTMENT OF HEALTH

Dr. BUECHNER. Thank you very much.

If you ever heard me speak extemporaneously, you will be thankful that I am going to read my comments.

Representative Claudine Schneider, members of the House Select Committee on Aging, thank you for the opportunity to address this critical topic, "Controlling Cancer: Choices for a Healthy Life."

My name is Jay S. Buechner. I am the chief of the Office of Data Evaluation at the Rhode Island Department of Health. It is my responsibility to provide data for targeting and evaluating public health programs in this State. Also, I am the former director of the State's cancer registry, which produced complete cancer incidence data for the Rhode Island population covering the years 1978 to 1982.

Mrs. SCHNEIDER. I am afraid you are going to have to speak directly into the microphone. Put it about an inch away from your mouth or something. I am seeing signs that they cannot hear you out there.

Dr. BUECHNER. At the end of that period, I authored an epidemiologic study of cancer incidence and cancer mortality in Rhode

Island. As you can see, I have a long involvement with the problems of cancer in this State.

Rhode Island has the highest age adjusted cancer mortality rate of any State. In addition, we have the second highest proportion of elderly of any State.

Since cancer rates are highest among the elderly, the net result is more than our fair share of cancer deaths every year. In 1983, there were 2,303 cancer deaths in Rhode Island. Our crude death rate was 28 percent higher than the national rate for that year.

Death rates for certain age groups were particularly elevated relative to national rates. These age groups were males, age 75 years and older, and females aged 85 years and older. As a result, most of the burden of excess cancer mortality in Rhode Island falls on the elderly.

Cancer now accounts for almost exactly one quarter of all deaths in Rhode Islanders and the proportion is growing. Ten years ago there were 20 percent fewer cancer deaths here in approximately the same size population. During that same 10-year period, the death rates for all other major causes, including heart disease, strokes, accidents and pneumonia, have declined substantially. Only deaths from cancer have risen.

If these same trends hold, cancer will be the leading cause of death in Rhode Island in 20 years. Some epidemiologists believe these trends will accelerate and that cancer will obtain the leading rank by the year 2000.

What is the reason for these terrible numbers and ominous predictions? There are many reasons that the numbers are high, but there is only one reason that they are increasing, that reason is cigarette smoking and it has spawned an epidemic of lung cancer among Americans, especially among elderly Americans.

Lung cancer has risen from the status of an unknown disease early in this century to become the leading cause of death among cancers for both men and women. It is the overwhelming dark cloud in a picture that is otherwise not discouraging.

This picture was best presented in a review of cancer epidemiology by Richard Doll and Richard Peto, that was commissioned by the Office of Technology Assessment of the U.S. Congress and presented in the Journal of the National Cancer Institute in 1981.

That article was entitled "Avoidable Risks of Cancer in the United States" and is the basis for current estimates of the percentage of cancer deaths that are preventable. Doll and Peto estimate that nearly 90 percent of all lung cancer mortality in 1978 was due to tobacco and that the observed increases in lung cancer in both males and females over the past half century, and I quote, "are largely or wholly caused by the delayed effects of the adoption decades ago of the use of cigarettes."

They go on to show that, and again this is a quote,

> The aggregate of all nonrespiratory cancers has taken a fairly constant toll among males for half a century, with about a ten percent decrease among younger men in the past decade, and the total nonrespiratory cancer death rate among females has been decreasing rapidly for half a century, due not chiefly to improved treatment but rather to decreased onset rates.

Simply stated, cancer incidence and cancer mortality rates have been holding steady or declining in the United States for as long as

we have accurate records, except for lung cancer. What this implies for public health efforts is clear and encouraging.

First, the cause of observed increases in cancer rates is known and the means of correction is straightforward, if not easily obtained, that is, lower the rate of cigarette smoking in the population.

Second, the causes of cancers other than lung cancer are very likely to have been part of our environment and lifestyle for many years, and the spectre of unknown carcinogens being recently introduced into the environment or food cycle can probably be discounted.

Because we are dealing primarily with constant causes and effects, all the data collected over the past half century can provide direction for current efforts in cancer prevention and detection. The conclusion I come to from these statements is that the largest part, by far, of the public health effort to prevent new cases of cancer should address personal risk factors of longstanding and not unproven environmental hazards.

First among these personal risk factors is, of course, cigarette smoking. It is an area of health-related behavior in which cancer prevention activities are likely to obtain quick and certain improvement in cancer rates. As Doll and Peto point out, lung cancer risks at age 60 depend strongly on cigarette smoking during the previous decade of life and also strongly on cigarette smoking during the decade from age 15 to 25.

It is clear that antismoking efforts must target both the populations. It is also clear that the specific programs must be drastically different for these two groups, given their personal incentives and time horizons.

This is an example of how health data can be used to design and later evaluate efficient public health programs for cancer. Local health data can be used to target programs even more specifically to those who will benefit from them.

A broader conclusion concerning the direction we should take in combating cancer in Rhode Island and in the Nation can be drawn from the study of Doll and Peto. They state that at least part of the moderate apparent improvements in cancer survival rates over the past 30 years is an artifact resulting from changes in data collection methods.

To quote directly,

> Changes in treatment for many types of cancer have chiefly improved palliation rather than cure the disease, and the true cure rates for many of the common types of cancer have probably changed very little since 1950.

I interpret that as saying that the immense resources expended during this period in the development and testing of treatment modalities have not solved or greatly abetted this public health problem. Although research and development must continue in this area on behalf of those who are, or will be, stricken with this dread disease, a substantial increase in emphasis on prevention and early detection is clearly warranted.

Decreases in nonrespiratory cancer incidence rates among females and young males are occurring already, presumably through reductions in personal exposure to risks. These reductions are oc-

curring either spontaneously or as a result of the broad-based public health efforts in place during this period.

It is exciting to consider the benefits possible from public health efforts that are developed and evaluated scientifically, using the data resources available at the local and national levels. That is a challenge that everyone in public health welcomes.

In conclusion, the points I would most like to leave you with are these:

First, the best evidence we have says that most cancers are caused by risk factors of long standing in our society, and are therefore preventable at the current level of public health knowledge.

Second, the priorities for cancer control should be revised to emphasize prevention and early detection, where we can be virtually certain of positive results.

Finally, the most efficient programs of prevention and early detection will be local programs attacking local problems that are identified with local data.

Again, thank you for the opportunity to participate in this important hearing. I hope my comments have been of some help in the committee's deliberations in this area of great concern to all of us.

Mrs. SCHNEIDER. Thank you very much. Your comments have been very helpful.

I would like to attempt to summarize some of the statements made by each of you and then lead into a question. Essentially, what both of you agree on, as representatives from our State of Rhode Island, is that certainly cancer is preventable. Dr. Scott, you had made some remarks in particular about lung cancer, and so did you, Dr. Buechner, that if we were to stop smoking immediately, there would be some changes in the data that we are collecting.

The other comments that you made were in reference to prevention and early detection. Perhaps if every woman were to examine her breast more often and not be fearful of finding a lump but be anxious of finding one early on so that they can receive early treatment, and recognize that there are new treatments available, that we would be much better off.

Both of you really stress the idea of prevention and I wonder if you could elaborate a little bit more as to what other measures people can take to attempt to prevent cancer.

Dr. SCOTT. Well, again, I think you have to be specific. We say cancer is preventable. I think we mean that certain tumors, some tumors can be prevented. We don't know how to prevent all tumors. Lung cancer is the No. 1, preventable tumor. Not smoking is the solution for perhaps 95 percent of cases.

Radiation can also cause lung cancer. There is some notable tragedies where this has obtained.

On the other hand, we don't know how to prevent breast cancer. We can find it early through the mammography, and physical examination.

Mrs. SCHNEIDER. Exposure to sun, that is not part of the top three. But that is something that we as Rhode Islanders who are sun lovers can relate to easily.

Dr. SCOTT. You are right. I don't think we are ever going to get people out of the sun. There is a major psychological benefit, and a benefit of people feeling they look better with a tan, but people, especially of fair skin, should be very cautious about going out in the sun, and use a sun screen.

Sun screens are helpful and can be preventive. I am a little upset by the number of suntanning parlors that we see emerging, and I gather in a sun State like Florida, there are more sun parlors than we have in a non-sun State like Rhode Island.

Mrs. SCHNEIDER. Since both of you are State representatives, let me ask you some specifics about what the State is doing in this area. Insofar as restaurants are concerned, we all know that we as individuals should not smoke, but what about other people smoking? There has been scientific evidence indicating that secondary impact of smoke is also of great concern and at some point there was legislation proposed to ban smoking in certain public areas. Are either of you involved in that effort?

Dr. SCOTT. Yes.

Mrs. SCHNEIDER. Could you elaborate on that involvement, please?

Dr. SCOTT. There is a requirement now that there can be no smoking I think in elevators and public corridors in our public buildings. Moreover, in restaurants, I don't know the exact size of the restaurant, but after a given size, you have to have a smoking and nonsmoking area, and those should be clearly marked. Management should afford you an opportunity to be in one area or another. Our division of food protection and sanitation is charged with enforcing these regulations.

Should you go to a restaurant where this does not seem to be done, that is having a smoking and nonsmoking area, you certainly should call the department of health and we will investigate. We have developed a smoking policy in the department of health which tries to take in mind both the problems of the smoker, because it is so difficult to stop, and the rights of the nonsmoker.

This policy is something that we would like to see more widely applied throughout State government and other institutions, but so far it is just in the health department.

Mrs. SCHNEIDER. I am sure a couple of people involved in the Federal Government would like to see that policy, too, particularly from my office because we don't give that freedom. We have a no-smoking policy in our office, no smoking or else.

I would like to further inquire as the head of our department of health in Rhode Island. I think what is disappointing to me is that the American Cancer Society had very much of a public awareness campaign going on years ago. As a matter of fact, I am thinking 15 years ago, and that is how I myself knew as a youngster, as a 25-year-old, that I should be concerned if I found a lump on my body.

Now, I don't see that same type of advertising giving the seven warning signals that one should be aware of. Do you have a cancer prevention or detection program that the State is orchestrating, perhaps in conjunction with the public affairs forces of some of the major TV stations, or any of the other public outlets?

Dr. SCOTT. Not enough, and we are actually constructing some programs right now. I am not prepared to speak about the specifics

as we try to get everybody lined up and committed to it, but I think there are a number of areas where we will be working.

We have certainly been very active on the smoking front. We have been very active and associated with the American Cancer Society in the colorectal program, but I think we now need to get into breast, talking about sunshine and the like. It is a terribly important part of this overall effort to make people more aware of what they ought to do.

Mrs. SCHNEIDER. I just might add one little footnote, a piece of information that I garnered a couple of weeks ago. I had a speaker come to Rhode Island who spoke at Brown University. He was a cardiologist from Harvard Medical School. And in particular, he was talking about the value of fish in your diet as it relates to heart attacks. But the other thing that he pointed out and that I had had experience on in my Science and Technology Committee, was the fact that it is believed that fish oil or cod liver oil, or you can buy the little capsules if you don't like the taste of it, now they are doing great research in the area of breast cancer, indicating that the more fish oil one consumes, the less likely one is to obtain breast cancer.

Those of you who might be interested, considering the fishermen might like to be doing more business, to certainly eat more fish would help Rhode Island's economy enormously.

Now, I can call upon my colleague, Mr. Blaz, for some questioning.

Mr. BLAZ. I didn't have a question. I was just enjoying the exchange.

Since this appears to be a group of nonsmokers, may I also announce that the last question I have on my interview sheet in Washington is "do you smoke," and if the answer is yes, then the conversation is over. I don't hire anybody who smokes.

But last week I came back from San Francisco on a major airline and as we got airborne, the lady announced that for the first time there were 90 percent of the people in the airplane were nonsmokers, so the whole aircraft was declared nonsmoking and a round of applause broke out, and I guess we are making some progress folks.

Dr. SCOTT. Oh, yes, we are.

Mrs. SCHNEIDER. Congressman Lightfoot.

Mr. LIGHTFOOT. I have to admit I have got one smoker, but I hired a guy, he chewed. So he is seated by an open window at all times. If I can have your permission, I would like to do something.

We don't normally involve the audience in these things but since we are talking about smoking, can we do a little informal poll?

Mrs. SCHNEIDER. Certainly.

Mr. LIGHTFOOT. How many of you smoke now? Hold up your hand.

[Audience response.]

Mr. LIGHTFOOT. How many used to smoke at some time during your life?

[Audience response.]

Mr. LIGHTFOOT. Progress. OK.

I appreciate both of your gentlemen's testimony. No. 1, that you talked in plain language that us human folks can understand, but I would bring up one question. Since you are involved with the State

agencies and we are coming at you from the Federal level, and there is a natural reluctance for government to intrude in our lives, but what can we at our level do to help you in your efforts through publicity, whatever?

Mrs. SCHNEIDER. Cigarette taxes.

Mr. LIGHTFOOT. There you go. What do you see our role in this? What can we do to help?

Dr. SCOTT. Well, you know, it is so complicated. The tobacco industry obviously is an important phenomenon in this country, but ultimately, I think that some 300,000, in excess, deaths a year occur as a result of the cigarette and we are going to have to come to grips with that and have to deal with the tobacco crop as a matter of national policy.

Needless to say, that is one big order, but I think we need to start talking about how can you deal with a very important economic interest and seek ways to use the land for other purposes.

The support, I think, of biomedical research is very crucial. Here we need more studies of methods to help people quit smoking. This effort needs to be expanded.

Mr. LIGHTFOOT. I thank you, and appreciate that. I would say that as a youngster I took a lot of cod liver oil, but it didn't have anything to do with breast cancer.

Mrs. SCHNEIDER. Hopefully you will have a strong heart for a long, long time.

Dr. Buechner, I would like to ask you a question as one who has directed the Rhode Island Cancer Information System. What is the status of Rhode Island's Cancer Information System today?

Is it still in existence? If someone suspects they have a problem, I would assume their first instinct is go to the doctor, but what exactly is the Rhode Island Cancer Information System all about?

Dr. BUECHNER. The Rhode Island Cancer Information System was not a public information system.

Mrs. SCHNEIDER. Was? It no longer is?

Dr. BUECHNER. No longer is in that form. I will explain that in just a minute.

It was not designed to provide the public with information on cancer preventive detection or treatment. It was essentially a statewide tumor registry and it is being continued by all the hospitals involved.

It was funded for a 5-year period with Federal funds from the National Cancer Institute and those terminated in July 1983. The hospitals that participated are still collecting information concerning their patients, which include about 80 to 90 percent of the State's cancer patients.

There is a public information effort through the American Cancer Society for people who have particular problems, the Cancer Hot Line, and that is very well subscribed and very well staffed.

Mrs. SCHNEIDER. So if people do have questions, they can call the Cancer Hot Line and they can just get that through information on the telephone?

Dr. BUECHNER. Yes.

Mrs. SCHNEIDER. Another question I have has to do with one of the other purported causes of cancer and that is the environmental

causes. As we all know here in Rhode Island, we have some significant difficulties with hazardous waste disposal and polluted waters here and there and that sort of thing.

To what degree are you collecting data or doing epidemiological studies in different geographic areas as to the cancer incidences around certain area? For example, around the Picillo pig farm?

Dr. BUECHNER. Well, without a statewide registry, that is very difficult. The analyses that we do conduct are as those problems are identified and will be specific to the areas, such as there was a great effort around the discovery of Temik in drinking water in South County and quite a bit of epidemiology was done around that problem.

Mrs. SCHNEIDER. Are there any ongoing efforts to track those people who lived in those areas?

Dr. BUECHNER. Not to my knowledge.

Mrs. SCHNEIDER. Do you think that would be advisable—if we had the State resources, of course?

Dr. SCOTT. I go back and forth on this. It is incredibly complex dealing with the very small trace exposures in the environment.

I think we take them seriously, and we do what we can to minimize exposure; therefore, anybody who lives around that particular dump, or any dump, has their well water monitored on an every 6-month basis and if they are above given action levels, they are supplied with bottled water.

We are now facing the issue of asbestos exposure, especially in the schools. I am sure you all heard about that. Now, we know asbestos is a terribly dangerous thing, but we don't know at what point is not dangerous or whether any exposure is dangerous.

The other thing that is terribly difficult is to know who in fact is exposed, because people are so mobile and their eating and drinking habits vary so much.

So you always hear, gee, we have a lot of problems with these studies. Moreover, we don't know how to identify people who should stay away from the exposure. Certain people are at greater risk than others. In the next 10 or 15 years, the biology of risk would be better defined. Such information will be very useful.

Mrs. SCHNEIDER. Well, I thank you both for your very expert testimony. I am most anxious to continue to work with both of you on an issue that is exceedingly pressing to Rhode Island. Thank you very much for your testimony.

Now, I would like to call to the witness stand, Tricia Leddy, who will talk to us about nutrition health care; and Dr. Frank Cummings.

I would also like to add that upon deciding to hold this hearing here in Rhode Island, I invited the rest of the Rhode Island delegation to attend and I received a telephone call from our very illustrious Senator—Senator Pell—telling me that he regretted that he had other compelling business and could not be with us today.

But I just noticed in the audience that we are very honored today to have his righthand woman, Mrs. Noella Pell. So, Noella, you might just say hello.

And we certainly thank you and the Senator for your interest in this issue, and also for the leadership that Senator Pell has provided in pursuing some solutions to the problem.

I realize there is a bus at 2:30 and many of you would like to be on that bus. However, I will say we also have accommodations for you at the 4:15 bus.

This hearing will be over at approximately 4 o'clock and the testimony that we are about to hear on nutrition I think is exceedingly valuable, so we will have a very quick recess at about 2:25. But before that time, I would like to take the opportunity to hear from these two witnesses because I think all of you will benefit from the outstanding testimony that they have available.

Tricia Leddy is the chief at the office of nutrition services at the Rhode Island Department of Health. She is responsible for establishing the Nutrition Hot Line, and I hope that all of you have taken advantage of this Nutrition Hot Line because it provides you with an enormous amount of information as to what might be good for you to eat in your particular health situation.

She has also worked with the Women's and Infants' and Children's Program in South County and provided nutritional counseling to the University of Rhode Island community.

Please begin your testimony, Tricia.

STATEMENT OF TRICIA LEDDY, CHIEF, OFFICE OF NUTRITION SERVICES, RHODE ISLAND DEPARTMENT OF HEALTH

Ms. LEDDY. Thank you. How many of you know someone who has had cancer? Almost everybody. And when we do know someone, we often ask, what caused it? And then, what could have been done to prevent it?

The search for the causes of cancer has been an important branch of cancer research. In the course of this research, it has become clear that most cancers have external causes, and, in principle, should therefore be preventable.

What can these external causes be, though? Many factors in our environment are potential causes of cancer. They include the air we breathe, the water we drink, the regions in which we live and work, and the foods we eat. The foods we eat. That is why I am here, as a nutritionist from Rhode Island Department of Health, to inform you about the connection between diet and cancer prevention.

The National Research Council is considered a nonpartisan authority on science and technology. It has been commissioned by the National Cancer Institute to compile all the research that has been done to date on diet and cancer. The research continues but the National Research Council has determined that there is now enough evidence to establish a link between diet and cancer prevention, and so they have published interim guidelines for diet and cancer prevention. That is what I am going to describe to you today.

Four of these guidelines are directed to us as individuals concerned about our health. If we follow these guidelines, we are likely to reduce our risk of cancer. The first guideline: To decrease fat to 30 percent of total calories. Americans now consume approximately 40 percent of our calories in the form of fat. Increased fat consumption has been associated with an increased incidence of breast cancer and of colon cancer.

So how can we decrease fat in our diet? Choosing low-fat or skim milk dairy products, choosing lean proteins; lean cuts of meat, choosing fish and chicken more often, dried beans or tofu. Also, decreasing our intake of polyunsaturated sources of fat: condiments like butter and margarine, mayonnaise, sour cream, and cooking oils; so decreasing our consumption of fried foods.

The second guideline is to increase our consumption of fruits, vegetables, and whole grains: whole grain cereals, whole grain breads. Especially within this category it has been found that certain foods have a special preventative effect on certain cancers. Namely; vitamin C foods, citrus juices and citrus fruits. Vitamin A foods, which include dark green leafy vegetables, broccoli, brussel sprouts, dark yellow or orange vegetables like carrots and yams. Also cruciferous vegetables have been found to have a preventive effect; broccoli, cabbage, cauliflower, brussel sprouts and kohlrabi. Eating these foods will help us prevent certain cancers.

Third guideline: To reduce our intake of salt-cured, salt-pickled and smoked foods. These foods have been linked with an increased incidence of cancer of the esophagus and stomach.

The fourth guideline: if you are going to drink alcoholic beverages, do so only in moderation. An excessive intake of alcohol has been associated with cancers of the upper gastrointestinal and respiratory tracts.

In addition to these four guidelines directed to us, there are two recommendations directed toward Federal and State agencies. The first is to continue to monitor our food supply for cancer-causing additives and contaminants. The second is that further efforts should be made to identify substances called mutagens in foods and determine if these mutagens are cancer causing.

"What is a mutagen?" you might ask. Mutagens have the ability to change the genetic makeup of a cell and therefore, because cancer also does this, they are often suspected of causing cancer. Mutagens have been found, for example, in charcoal-broiled meats, but most mutagens found in foods have not been studied enough to determine if they are in fact cancer-causing. So further research is needed before the National Research Council has enough evidence to issue guidelines for us concerning our intake of mutagen containing foods.

There are two limitations to the guidelines that I have just told you about. First of all, the guidelines for diet and cancer prevention are just that, cancer prevention. Some people might jump to the conclusion that if something is going to help prevent cancer in the future that it may also help to treat or cure existing cancer. This is not true, unfortunately. There is no evidence that any of the dietary modifications that I have suggested will cure or treat existing cancer. However, it will significantly reduce our chances of getting cancer in the future.

That leads to the second limitation, and that is that we are talking about risk reduction, not a 100-percent guarantee of never getting cancer. As Dr. Scott pointed out earlier, there is nothing that we can do that can 100 percent guarantee that we will never get cancer. However, if we follow all of the guidelines that I have outlined, the National Research Council has determined that this will significantly reduce our chances of getting cancer in the future.

Now, is there anyone in the audience who might need to improve their diet on any one of the areas that I have mentioned? All of you. I think all of us. Don't you think all of us can use a little bit of improvement sometimes? Because I only had a few minutes to speak, I brought some practical suggestions on how you can incorporate these guidelines into your daily diet.

First of all, the suggestions I have summarized are in the American Cancer Society pamphlet available at the publications table. This will summarize the guidelines and also tell you how to incorporate them into your daily meal plans. If you have any further questions, you can call me on the Nutrition Hot Line. The number is 1-800-624-2700 toll free in Rhode Island.

Mrs. SCHNEIDER. Thank you very kindly for your input. We are anxious to also hear from Dr. Cummings before we take our break, and I think that many of the attendees here will benefit greatly from what Dr. Cummings has to share with us. Dr. Cummings is an associate professor of medicine from Brown University. He practices at Roger Williams Hospital, and he serves as a consultant to the VA Hospital, the Women and Infants Hospital, Miriam Hospital and a whole number of others. He is here today testifying on behalf of the Colorectal Health Check Task Force, and, Dr. Cummings, we welcome you and look forward to what you have to tell us.

STATEMENT OF DR. FRANK CUMMINGS, COLORECTAL HEALTH CHECK TASK FORCE

Dr. CUMMINGS. Thank you. I am here today to tell you about a program that is called Check. Check is Colorectal Health Check. It is a program developed by the American Cancer Society whose overall goal is to reduce the mortality from colorectal cancer, one of the major causes of death from cancer in both men and women. I serve as chairman of the colorectal steering committee of the Check Task Force.

It is estimated that approximately 55,000 individuals will die of colorectal cancer in 1985; there will be approximately 140,000 new cases this year. In Rhode Island, there will be close to 400 deaths from colon and rectal cancer, with approximately 950 new cases this year. The death rate from colorectal cancer in the State of Rhode Island has exceeded the national average by 10 to 15 percent since 1950. The American Cancer Society has launched a 3-year project to bring attention to the public the importance of early detection efforts.

The Rhode Island division offers professional and public education and information developed to heighten the awareness to the colorectal cancer problem and to encourage individuals to employ regular screening practices, including regular stool blood tests, digital rectal examination, and proctosigmoidoscopy, or procto. The present 5-year survival from colorectal cancer is approximately 50 percent, but with detection at an early stage, 75 percent of patients may be cured following surgery.

The American Cancer Society guidelines for the early detection of colorectal cancer, in asymptomatic people, include annual digital rectal examination from age 40 on, annual stool blood testing from

age 50 on, and sigmoidscopy every 3 to 5 years from age 50 years on, after two initial examinations done a year apart have been negative. Ninety-three percent of colorectal cancer occurs after the age of 50, with the majority occurring after the age of 70 years. Thus, this program is of particular importance to elderly individuals who should be familiar with these recommendations and should discuss them with their physicians.

The American Cancer Society has distributed door to door and through local pharmacies, information about colorectal cancer and coupons to obtain a packet for a stool blood test, which could be returned to the Rhode Island Department of Health for testing. Results are then forwarded to the patient and their listed physician for appropriate followup. Approximately 38,000 packets have been distributed throughout the State of Rhode Island this spring.

The local effort for Check was coordinated by a task force of the Rhode Island Division of the American Cancer Society. Representatives from the media, labor, and industry, unit volunteers, health officials, pharmacists, nurses, physicians, and cancer patients joined together to promote dissemination of the topic, colorectal cancer, throughout the State. Physicians in each area of the State were provided information about colorectal cancer and the importance of early detection through regular screening examinations. This was given to family practitioners, internists, gynecologists, urologists, and other members of hospital staffs.

Considerable effort was extended by these volunteers to overcome the stigma previously associated with this embarrassing subject. We have now gotten the subject of colorectal cancer out in the open and in the public eye. The ultimate success of the program in Rhode Island, and throughout the Nation, will not depend upon what we have told physicians and the public about the disease, but will depend entirely upon support of these programs and upon public responsibility to maintain their own regular screening health practices. Improvement in the present cancer mortality figures for the State of Rhode Island will require combined efforts of both the medical profession and we, the citizens at large. Thank you.

Mrs. SCHNEIDER. Thank you very much, Dr. Cummings. Now, I thank you very much for your testimony. I would like to share with all of you that there was another doctor that I had invited to come and testify this afternoon, who wasn't able to make it. He is a doctor from Yale, and his particular area of expertise is connecting the psychological and the emotional connections to cancer. He called me and he said he was very, very sorry that he could not be here, that he wanted me to bring one message to all of you. He said sometimes he hopes he will have the opportunity to come to Rhode Island to carry the message himself, but that one message he said was that if you think you are going to get cancer, you probably will, and that your mind plays an incredibly important role in controlling your health, whether it be a heart attack or cancer, or whatever.

It is not the "be all" and "end all," but as we heard from our first witness, a positive attitude is critically important. As we heard from some of the other witnesses, it is also critically important that you focus on the early detection of any strange ailments

or things going on in your body that you might experience and also prevention, insofar as stopping cigarette smoking and attention to the sun and a number of other things, and certainly, the nutritional proposals that Tricia Leddy has provided us with, indicate that we ought to have a diet more filled with fish and less meat. As I said before, it will help Rhode Island's economy. Also a greater emphasis on fruits and vegetables.

At this time, I know that many of you have to leave. We will have a quick, 5-minute recess, and then we will return to ask questions of these two witnesses, and those of you who are able to stay, we certainly appreciate it. Those who are not able to stay, we thank you for coming and hope that you will leave here with a positive attitude and share this information that you have garnered with others. Thank you for coming.

[Recess.]

Mrs. SCHNEIDER. Could I have your attention please. We are going to convene the Select Committee on Aging hearing on cancer. We have just heard some testimony from Tricia Leddy and Dr. Frank Cummings, and let us begin with a number of questions. Would my colleagues like to begin? Congressman Lightfoot, would you like to start the questioning?

Mr. LIGHTFOOT. Thank you. Tricia, your testimony basically was what we could do from a dietary standpoint for preventative maintenance, so to speak, and you talked about a number of things. You mentioned several guidelines, and first of all, your first guideline was the total amount of fat in our diet, both saturated and unsaturated. Again, this may be a bit redundant, but in terms of meat and protein, what kind of guidelines should our people follow when they go to the store, what should they look for, what are the visible clues when they go to the meat counter for buying the right kind of meat that will work?

Ms. LEDDY. When we go to the meat counter, if we are going to choose red meats, we should be choosing meats that are lean, that is meats without the white, visible fat or marbling in the meats. We should choose red meats less often, perhaps limiting red meats to two or three times a week and substitute with other high protein but low fat meat alternatives like chicken, fish, dry beans, kidney beans, lentils, or soybean products like tofu.

Mr. LIGHTFOOT. Thank you.

Mrs. SCHNEIDER. Any other questions, Dr. Cummings, or anybody?

Congressman Blaz.

Mr. BLAZ. Let me follow up on the meat, because I have a friend in the meat-producing business, and he argues very vehemently with what you just said. I don't happen to agree with him, but he says that it is all a concerted effort on the part of the chicken and fish people. Would you care to comment, how do you respond to a person like that, when he comes to visit me for dinner, he insists on not having chicken or fish. Is this a widespread knowledge of what you said about the red meat and the hazards that are involved in it?

Ms. LEDDY. I think that what is widespread knowledge about red meat is the link between the fat in meat—saturated fat—and heart disease; that is well publicized, wouldn't you say?

The evidence on total fat intake and cancer is quite new, and this would include not just saturated forms of fat that we have been used to watching out for in our diet, like red meats or high fat dairy products, but also includes decreasing the polyunsaturated forms of fat like margarine, cooking oil, corn oil. We want to eat less total fat, whether it is saturated or polyunsaturated. When we have a choice, the little amount of fat we do eat, we would like to have unsaturated rather than saturated for the heart disease prevention value of it.

Mr. BLAZ. Let me ask the following question, if you have to have meat, there are those who tell me that whatever you do, don't charcoal broil it, and when you do that, it takes a lot away from the meat, as you know. Now, what is the alternative to charcoal broiling, boiling the meat?

Ms. LEDDY. Certainly we could boil meat like pot roast. Pot roast and other forms of stew meat are quite low in fat. These forms of meat that need water to make them tender are low in fat, and those are the types of meat that would be perhaps preferred. Baking, oven broiling, and roasting are also preferred alternative cooking methods to charbroiling.

Mr. BLAZ. Thank you very much.

Mr. LIGHTFOOT. To follow up on that.

Mrs. SCHNEIDER. Certainly.

Mr. LIGHTFOOT. Just to follow up a little bit further on what Congressman Blaz was talking about, maybe up front, my home state is Iowa, and we are the second most rural district in the United States. And we also are the second or third oldest district, over 20 percent of the people in the district are over the age of 65, and being that they are in the red meat producing business for the most part, they tend to argue, look at me, I am 75, raised this way, how come, you know we don't have a higher incidence of cancer here than you do in Rhode Island, for example. So a lot of those arguments can be made.

I guess what I want to come back to you with, with all of us trying to look at it as unemotional as possible and being analytical about it, there was a great deal of concern in our part of the country that some of the research data that came out was released a little bit too soon, and was exaggerated in their findings, particularly on the nitrite thing where we had to eat 500 pounds of pork a day in order to get the same levels that were introduced into the laboratory animals.

I see now another area of the country is concerned about red dye No. 2, that you have to consume 785,000 cases of fruit cocktail, or what is it on cherries, I forget, 400,000 pounds of cherries, I think some such thing, which if you can eat that many, there wouldn't be enough Kaopectate to keep you alive anyway.

I guess the point I am getting at, those of us, our basic interest of all of us is to prevent, particularly in this instance, cancer, but in any disease, like heart trouble, it is all tied together, do we tend to sometimes overreact a little bit to the research, and should we try to pin it down a little tighter before we go public with it? Because I am sure this frightens people when they see some of this data, but I am just asking your opinion.

Ms. LEDDY. I agree, some data is released early. For example, who heard about the study that was released on pancreatic cancer and coffee about a year or two ago? In other words, one study. That was released in one particular journal and was reported by the newspaper. This isn't the kind of data that I am reporting today. I am reporting data that has been compiled from many, many studies, and the National Research Council has determined that the evidence in fact is there for the findings that I have reported today.

Concerning total fat intake, there has been found to be a relationship between total fat intake and cancer incidence, both by way of population based studies, using epidemiological data and backed up by laboratory data, using animal experiments.

But as far as meat is concerned, we are not saying people should give up meat and become vegetarians necessarily, we are saying everything in our diet should be eaten in moderation, and this includes red meat. We are saying control portion size. You don't need a 12-ounce steak, cut it in half. Choose the leaner cuts of red meat.

Mr. LIGHTFOOT. Common sense.

Ms. LEDDY. Yes.

Mrs. SCHNEIDER. I will pick up on your remark about moderation, because in the testimony of one of our earlier witnesses, Dr. Scott, he had indicated that 49 percent of the American people don't know what they can do to prevent cancer. If 49 percent of the people don't have a hint, at least if we are giving them that, there is some hint that certain kinds of cancer may be caused by X, Y, and Z, I think we are doing the appropriate public service, and we may not have, as so often occurs in science, we may not have conclusive evidence, but it is our responsibility as researchers or as policy developers to give an indication of what may happen to you. And I think the guidelines you set forth in your testimony earlier certainly should help to diminish the lack of public awareness about what we can do in terms of appropriately addressing preventive measures.

During the break, I had someone come up to me an say, "Why is this information not getting out to the schools?" Here are a number of people, seniors admittedly for the most part, who have said that during their youth they were exposed to very good nutrition, stews, home-cooked meals, and now as we have moved toward the fast-food trends, many of the young people, and also in the schools, there is an enormous amount of canned food, foods that have been processed, and really broken apart. Could you give us a little bit of insight as to what the Rhode Island Department of Health is doing to improve the education of young people when it comes to nutrition?

Ms. LEDDY. Yes; the Rhode Island Department of Health is doing a lot to improve the nutrition of schoolchildren. We have what is called the Providence Plan for Health Education, and this started in Providence but now has expanded almost statewide, where health educators go into the school systems and teach school children about basic nutrition as well as other health issues.

Mrs. SCHNEIDER. Do you think that is the appropriate approach, or should those kinds of things be taught by each individual teacher in those various classes, rather than have one individual go around intermittently to educate young people?

Ms. LEDDY. There are also ways that the teachers in the schools are being educated as to how to include nutrition into their curriculum. This is basically being done by the Dairy Council, which has a program for educating teachers. Since the department of health doesn't like to duplicate services, they are doing other things, like sending nutritionists around to the high schools to educate children. Also the department of education is very active in this arena having the Nutrition Education and Training Program under their auspices.

Mrs. SCHNEIDER. And to what degree are you utilizing volunteers, because there may be some volunteers in the audience who would like to go out and share their knowledge with young people?

Ms. LEDDY. I am not involved directly with the program in the schools, so I don't know if volunteers are being used at this point.

Mrs. SCHNEIDER. Dr. Cummings, another issue that we have not raised is the whole question of the role of genetics and heredity in the assessment of cancer, and I wonder if you could elaborate a little on that.

Dr. CUMMINGS. Clearly, there are some genetic aspects to cancer, and I think we are starting to understand more of those every day. If one looks at what genetics is, it is really looking at the machinery that makes cells unique and helps them to divide and to grow, and with some of the modern technology that we have today in medical science and the biologic sciences, we are learning much more about diseases and ways where we might be able to shut off some of that machinery, to make the cancer process revert perhaps to a normal process or actually to resolve.

In terms of genetics, as we know it today, there are many diseases associated with cancer. Some of the leukemias have a particular genetic background. Anyone who has a family history of cancer, there may be a relationship that is on a genetic basis with that.

Mrs. SCHNEIDER. Are there any types of cancer in particular where there seems to be a higher incidence of genetic relationships?

Dr. CUMMINGS. There certainly are. With respect to colorectal cancer, people who have a family history of that are at a slightly increased risk of getting the disease. There are conditions called polyps, or multiple polyposis of the colon, which is on a genetic basis, where that disease is transmitted from a parent to a child, and that person has an increased risk of getting cancer.

There are people who have breast cancer, who have a mother, or an aunt or a sister, who have three times the chance of developing breast cancer compared to those people whose mothers, aunts and sisters have not had breast cancer. It doesn't mean that all of them will get it, but it means that their risk of getting that same disease is increased over the normal person who has not had the disease. I think this is an important part of prevention as well, and that is to identify high-risk groups of individuals because they have more of a chance of getting the disease.

Dr. Scott talked earlier about the relationship of cigarette smoking and lung cancer. Not everyone that smokes gets lung cancer, but certainly more of those who get lung cancer have smoked than those who have not smoked. The same thing is true for identifying

high-risk groups in colorectal cancer. People with large polyps can have those polyps degenerate into cancer. Understanding the high-risk group is just as important, as following and monitoring them. Patients themselves should be aware of who might be in those high-risk groups.

Paying particular attention to screening practices is crucial to trying to change some of our present outcome with these diseases. That is in contrast to what is called screening, which is done in people who do not have symptoms. If you have symptoms, you clearly should consult with your physician about finding out why you have those symptoms. When you don't have symptoms, it is still just as important to practice screening.

If I can just add one plug for the American Cancer Society, you asked about volunteers to help Tricia, and I would say that any of the people in the audience who are interested in volunteering would be welcomed. The American Cancer Society is an organization known for volunteers. Each one of us, including those that sit on the board of that local society, and the national society, are volunteers, and we need the help of everyone, all you people in the audience, to volunteer.

We can find you something to do, whether it be in the nutrition area, whether it be educating other people or working with cancer patients or doing other things. This is crucial to the success of the efforts that we have, because it won't be done by the few of us who are physicians or those of us in Congress. We really need the support of the population at large to achieve some of the results we all would like to see.

Mrs. SCHNEIDER. Thank you very much for that public service announcement.

Congressman Blaz.

Mr. BLAZ. Dr. Cummings, in your testimony, you dwell primarily on the fact that we have a high incidence rate of colorectal cancer and that there should be an occasional checkup to make sure that we do not suffer from it, and aside from your comment on large polyps being particularly susceptible, I wonder if you might comment on Tricia's earlier statement that most of the cancer is caused from external sources, that perhaps most of them are preventable. Can you think of an external source that might be very contributing to the cause of colorectal cancer? In other words, what can we do with our diet? What can we do to help reduce the likelihood of getting colorectal cancer?

Dr. CUMMINGS. I would like to not limit myself just to colorectal cancer, because some of the things have already been said today, but I would like to reiterate because I think they are important. Clearly the major killer today is lung cancer, and that is related to smoking. I don't think there is any question about that. It is estimated that perhaps 85 percent of people who have lung cancer could have been prevented if we had been able to get the population to stop smoking. Now I can't get them to stop. I don't think any of us on this panel can get people to stop. They are going to have to do it themselves, and I don't know how to tell them. I have wrestled with that problem many years.

Mrs. SCHNEIDER. I can give you some pointers.

Dr. CUMMINGS. Clearly I don't smoke, so I feel from that standpoint I am ahead. Some people need that. Clearly it is an effort that we have to face ourselves and decide whether or not we are going to do it.

With respect to colorectal cancer, I think the most compelling argument to me, that there is a relationship between diet and colorectal cancer, is the epidemiological evidence that suggests that in other parts of the world where they don't follow the same dietary patterns that we do, whether it be in Rhode Island, Iowa, or wherever, but where they don't eat red meat, the meats high in fat in their diet, that their risk and the incidence, the number of people who get colorectal cancer, is much less than it is in this part of the country. So the efforts that you hear about, don't eat this and don't eat that, are based upon trying to have people's patterns of eating changed such that they don't take in as much fat in their diet.

You alluded to earlier the efforts in trying to reduce the risk of developing breast cancer, or getting a second breast cancer after you have had one, by modifying the diet of people. We can tell them what to do, and it is not 30 percent which is what Tricia wanted all of us to do for colorectal cancer, but it is really in that particular study moving it to 20 percent fat in the diet.

I think the real issue that we are going to see is whether or not any one of us could stick to a 20-percent fat diet for a number of years, and so I think that that is a very important aspect of one trying to modify things in a way that they will be acceptable, that all of us will be compliant to whatever the modification is. We are not complying yet to stopping smoking, which is our major killer. Colorectal cancer is right behind it, because more men and more women, together, die of that disease. Women are dying more of lung cancer today than they ever have, and it has become a major cancer death over breast cancer in this last year.

Mr. BLAZ. Thank you very much, Dr. Cummings, thank you, Patricia.

Mr. LIGHTFOOT. One last question. Dr. Cummings, if I interpreted your testimony correctly, you are having some problems with people coming forth to take the colorectal test, if I interpreted that correctly. Why, and is there anything we can do to help?

Dr. CUMMINGS. I think with respect to doing the stool blood tests, there are a couple of factors. It is an embarrassing subject, it is one that we have just gotten out into the open, not only in Rhode Island but throughout the country this year. That was one of the major goals of this program let's bring this cancer, one of the major killers, out of the closet and let's deal with it directly. Let's educate physicians and people, not that physicians aren't people, but other people—I hope we are anyway—to the fact that there are certain things we have to be on the lookout for.

We have to look for changes in symptoms, changes in our bowel patterns, or blood in the stools, some of the very obvious things that any physician hearing of would immediately come into his mind that colorectal cancer might be a problem. Having diarrhea 1 week and constipation the next, we don't always talk about these, but they are critical issues in trying to uncover this.

You have to go beyond that, you have to go to people before they develop the symptoms. The symptoms are just a recognition of

something going on that you then find. You have really got to find it early so that you can do something successful about it, and I think we are doing that. But it really is new, it is all new to people.

A year ago, we didn't have announcements on TV and radio, as we have had this year. We didn't talk about the annual screening examinations for colorectal cancer. We are doing that now. Tricia asked, and I would like to ask, how many people were aware and saw through their local pharmacy as they went to pick up medication or chewing gum, that there was in fact an effort by the American Cancer Society, and how many of them did pick up one of those little packets that they then could bring back?

I think that that is a very important aspect of this is letting people become aware of it. They were passed out door to door during the crusade of the American Cancer Society this year. There is probably some reluctance to bring those back too. I would encourage everyone in the audience who hasn't done it to go and pick up one of these packets from their pharmacy. Pick up some information that is there about colorectal cancer, and send it back to the Health Department where people working with Dr. Scott will test the packet, and the results will be given to the person and sent to their physician, if they list one.

I think it is important that we get into these regular practices, the same way we put our ties on in the morning and brush our teeth. I think we have to think about this, but since we don't have to do it every day, it is not always easy to remember it, but it is critical for picking up conditions early when they can be successfully treated.

Mrs. SCHNEIDER. OK, I thank you both very much and now I would like to call our next witness to the stand, Dr. Vincent Mor.

Dr. Mor is the director of the Center for Health Care Research at Brown University. I think we have already acknowledged that we are very fortunate to have Brown University here because of their role in addressing our health problems, and particularly in the area of cancer work.

Dr. Mor is also an associate professor in the Department of Community Health at Brown University and has been doing a great deal of research on issues covering everything from hospice reimbursement to nursing home quality, to long-term care utilization.

Dr. Mor, we welcome you, and you are free to give us your informal testimony if you like; your entire testimony will be incorporated in the record, so please proceed.

STATEMENT OF VINCENT MOR, Ph.D., DIRECTOR, CENTER FOR HEALTH CARE RESEARCH, BROWN UNIVERSITY

Dr. MOR. Congresswoman Schneider, Congressman Blaz, and Congressman Lightfoot, distinguished guests, ladies and gentlemen. My name is Vincent Mor and the reason I am here today, I believe, is because I am the principal investigator of a National Cancer Institute research grant that was awarded to Brown University and several of our affiliated hospitals. Dr. Cummings who was just here, is one of our co-investigators. The purpose of this study is to examine the factors that influence treatment choices made by

newly diagnosed elderly cancer patients, their families, and their physicians.

This particular research study here in Rhode Island is the largest of several projects funded by the National Cancer Institutes that were initiated in order to explore the special needs of the elderly cancer patient.

The pertinence of this program of study is particularly important because the Federal Government last year announced a goal to reduce the number of cancer deaths in the United States by 50 percent by the year 2000. Many of the features and issues that the earlier people spoke about are key elements in trying to reduce the mortality associated with cancer in the United States. To meet this goal, three courses of action have to be taken. First, discussed earlier, the American people must adopt healthier personal behaviors, particularly giving up smoking and in some sense modifying dietary habits.

Second, in addition to preventive activities, patients in the health care system must be more attuned to early detection efforts known to be effective. For example, breast self-examination, the early detection of colorectal cancer, and periodic checkups for patients, for individuals at all ages but particularly those over 55 when the risk of attracting cancer begins to increase at very high rates.

Finally, the third arm of cancer control, as it is called by the National Cancer Institute, is the early and prompt delivery of effective treatment, to patients, overcoming any geographic, economic, and other attitudinal barriers that prevent people from having complete access to medical care. It is this latter issue that the project that we are doing here in Rhode Island specifically examines.

As the population in the United States ages, the number of Americans that are diagnosed with cancer increases rapidly, so that persons between the ages of 50 and 54, 5 out of every 100 are likely to contract cancer during that time period. This risk almost doubles every decade until among those 85 and over, 23 out of 100 will contract cancer. As our population continues to age, the number of persons with cancer will increase.

We have made great strides in increasing the survival of people over 65 in the United States, and there is even talk that with the appropriate preventive health measures, that the likelihood of reducing mortality due to heart disease may also drop considerably. Therefore, the population in the United States is going to continue to age. Since the risk of having cancer increases with age, it becomes particularly important for the elderly to be attuned to their risks and what can be done if cancer is contracted.

Data from several research studies strongly suggests that for some kinds of cancer, older persons are less likely to have their disease diagnosed at a relatively early stage when there still appears in most cases to be some possibility that the disease can be arrested and cured altogether. Other studies more recently have suggested that older patients are less likely to receive aggressive cancer treatment than are younger patients once diagnosed. This is particularly the area that we are examining here in Rhode Island.

While it may not be clinically appropriate for an individual who is over 85, already sick with heart disease, to be exposed and sub-

jected to very extensive diagnostic testing when the disease may not be reversible in any case. On the other hand, for a healthy 85-year-old person to avoid checkups, or to think that the disease is irreversible and doesn't have any chance of cure, is incorrect and may unnecessarily negatively influence their chances of survival.

This is true for people 65, 75, and 85 years old. We at Brown University, in cooperation with the New England Long-Term Care Gerontology Center, as well as Brown University affiliated hospitals and other hospitals in the State, have undertaken a large scale project to identify the patterns of treatment of all newly diagnosed lung, breast, and colorectal cancer patients between the ages of 45 and 90. Our central question is, is there really a difference in the kinds of treatment that the patients newly diagnosed with cancer receive as a function of their age? If there is, what factors appear to influence treatment choice? Is it the attitude of the older person? Is it the attitude of the family? Is it some bias associated with age that the physicians exercise by not pursuing particular diagnostic test sufficiently aggressively?

At present, we don't know the answers to those questions. However, we here in Rhode Island have an excellent opportunity, because of the cooperation of the Department of Health and area hospitals to make great strides in trying to answer these questions arriving at important educational, as well as policy relevant answers.

These should mean that in the future, the area of cancer control can be expanded to not only include the prevention of the disease but also the rapid implementation of diagnostic and treatment services for all patients, all persons, regardless of their age, as long as they are interested in having that kind of treatment.

Thank you.

[The prepared statement of Dr. Mor follows:]

PREPARED STATEMENT OF VINCENT MOR, PH.D., DIRECTOR, BROWN UNIVERSITY CENTER FOR HEALTH CARE RESEARCH, ASSOCIATE PROFESSOR IN THE DEPARTMENT OF COMMUNITY HEALTH, BROWN UNIVERSITY PROGRAM IN MEDICINE

Congresswoman Schneider, Distinguished Guests, Ladies and Gentlemen. My name is Vincent Mor and I am the principal investigator of a national cancer institute research grant awarded to Brown University and several affiliated hospitals to examine the factors influencing treatment choices made by newly diagnosed elderly cancer patients, their families and physicians. This research program is the largest of twelve projects funded by the National Cancer Institute and the National Institute on Aging to explore the special needs of the elderly cancer patients. The pertenance of this program of study is particularly important in light of the federal goal of reducing cancer mortality by fifty percent by the year 2000. To meet this goal, three courses of action must be taken. First, Americans must adopt healthier personal behaviors such as giving up smoking. Secondly, in addition to preventative activities, patients and the health care system must be more attuned to early detection efforts known to be effective. Finally, the third arm of cancer control is the early prompt delivery of effective treatments to diagnosed patients by overcoming geographic, economic, and attitudinal access barriers to high quality medical care. This latter is the one which our project addresses.

As the U.S. population ages, the number of Americans that are diagnosed with cancer increases because the risk of developing cancer increases rapidly with age. Between the ages of 50 and 54, five out of every one hundred persons contracts cancer. This risk of developing cancer doubles almost every decade until the risk of developing cancer is 23 out of 100 persons over age 85. The death rate due to cancer is also substantially higher among the aged, peaking at 14 per 100 persons over age 85. As the entire population continues to age, the number of cancer deaths will increase.

Data from several recent studies suggest that older persons diagnosed with certain cancers are more likely to have their disease diagnosed at a more advanced stage than is the case for younger patients. Other studies have also found that older patients are less likely to receive aggressive cancer treatment than are younger newly diagnosed persons with a similar type and stage of cancer. These latter studies need to be confirmed and, more importantly, we need to understand why the differences due to age exist. Clearly, it may not be clinically appropriate to subject an 85 year old person already sick with heart disease to elaborate diagnostic testing to determine the exact nature of a tumor that can not be reasonably removed given the patient's condition. On the other hand, the social biases known as "agism" are pervasive. These biases influence the perceptions of the aged person experiencing symptoms, their family members, and caretakers as well as their physician. Research findings from various projects suggest older patients report their symptoms differently, family members tend to expect deterioration due to advancing age, and physicians tend not to spend as much time with their elderly patients even though the complex pattern of multiple chronic illness the aged have required additional time and thought.

Here in Rhode Island, we at the Brown University Center for Health Care Research and the Southeastern New England Long Term Care Gerontology Center along with the university affiliated hospitals and together with the cooperative participation of almost all hospitals in the state are attempting to understand the age related differences in cancer diagnosis and treatment in order to gain insight into the approaches that might be effective in increasing early detection of cancers and the rapid delivery of effective treatments to all who can benefit, regardless of age. The study compares the use of and response to cancer treatments by older and younger newly diagnosed cancer patients. We are still in the early stages of the project. Cooperation has been excellent, and we hope to be able to answer many of the pressing questions in this area.

As a society, we must be sure that the current concern for inappropriate high technology treatment of the terminally ill does not inhibit efforts to aggressively treat the aged cancer patient. Acquiring cancer is no more a terminal condition among the aged than it is in the younger age groups, and while it is more prevalent among the elderly, it is by no means a necessary condition of aging.

Mrs. SCHNEIDER. Thank you very much for that insightful testimony. I would like to begin the questioning with an inquiry as to one of the early points that you made that your responsibility is to examine the factors influencing treatment choices made by newly diagnosed elderly cancer patients.

Much of that has to do with the options that the doctors present to the patients. In your study, what kind of options are you finding that the doctors are providing patients with?

Dr. MOR. It is still too early to tell from any of the data that we have in our study, regarding what kinds of options the physicians are actually presenting to their patients.

We have been underway for about just under a year now, and hopefully we will be able to answer that question. We are obtaining information on the kind of recommendations that the physicians are making for their patients, the kinds of options that the patients are considering, as well as the factors that the physicians say influence their choice in making a recomendation and communicating that recommendation to the patient.

As an aside, one of the things that has traditionally been said about the relationship of the physician and the patient is that physicians tend not to, or are very worried about telling the patients about their diagnosis, particularly in the case of cancer because everyone believes that cancer is a terminal disease.

In fact, we are finding that that is very rarely the case, and the large proportion of older persons, or all persons that we have spoken to, were directly told by their physicians about their diagnosis.

Mrs. SCHNEIDER. Can I assume that they were also given a percentage rate at which they were expected to be cured. We had some of that mentioned earlier in our testimony here, and I wonder, is that a trend among doctors to say, well, you have a 25 percent chance of survival?

Dr. MOR. I can't say that. We don't specifically ask that. We do ask whether or not the patients were told about their prognosis from the physician, but we don't ask any more detail about that.

I am not necessarily sure it is that good an idea to say 25 percent or 30 percent, mostly because the data are not generally good enough, and they change very rapidly.

Mrs. SCHNEIDER. Well, I happen to be a believer also that one should not be giving such assessments to patients, having had a lot of personal experience with a number of people and recognizing the correlation between the mind, the body, and the emotions. It seems many terminal cases turn out to be not so terminal and I think that oftentimes what needs to happen is more hope, more love and attention to assuring the ultimate cure of a cancer patient.

Dr. MOR. That is an excellent point.

Mrs. SCHNEIDER. The other thing that you mentioned is that certain cancers are more likely to have their disease diagnosed at a more advanced stage than is the case for younger patients.

Do you think that is primarily, I realize these are early findings that you have, but is that primarily because seniors are of the attitude that if they have an ache or pain it is all an experience in the aging process and they are therefore less inclined to have it checked out by a doctor?

Dr. MOR. The speculation noted in the literature, and other studies is now a fairly well-established relationship based on large scale tumor registries in Iowa, Utah, and other places around the country. Generally speaking, older breast cancer patients are diagnosed later than are younger breast cancer patients.

There is really no difference in terms of age from the existing information with respect to colorectal cancer, possibly because of the nature of the disease and how symptoms are recognized, but I think particularly with breast cancer and also with cervical cancer, there are probably cultural biases that older people are less likely to present themselves and feel embarrassed, just as Dr. Cummings spoke about, embarrassed about certain physical phenomena that are otherwise fairly straightforward, and it could very well compromise their survival.

Mrs. SCHNEIDER. Thank you very much.

Congressman Blaz.

Mr. BLAZ. Dr. Mor, you mentioned that the national effort to reduce cancer by the year 2000 by 50 percent is related, I think, to some degree do to the effort here in Rhode Island.

I heard earlier testimony that there is an unusually large incidence rate here in Rhode Island and I wonder if you might care to comment as to why you think there is that dubious honor to this tiny State?

I would be interested because I think, I hate to say it, that my island is also affected by this, and we have a large percentage, as well, in a different disease, and I am just wondering what you think the reason might be?

Dr. MOR. I think the strongest speculation here in Rhode Island, because there is a higher than expected age-adjusted mortality rate appears to most people to have two possible explanations.

One, the particular ethnic mix in the population here in Rhode Island, and two, the possibility that there may have been 30 or 40 years ago, higher than average military industry that may have created additional carcinogens in the environment.

However, it is not my area, so I am really not able to comment any further. I think Dr. Buechner, who was here earlier, was probably able to comment at least on the statistical aspects of that better than I can.

Mr. BLAZ. Thank you.

Mrs. SCHNEIDER. Doctor—Congressman Lightfoot.

Mr. LIGHTFOOT. I just got promoted.

Somewhat of a general question, Doctor, and if you could relate it to Rhode Island and maybe the Nation as a whole; as we look at this aging population, and what you alluded to in your testimony, do we have the resources and the facilities and the support groups that we are going to need to handle the problems that may be foreseen maybe in the future?

Dr. MOR. That is a very good question. I would imagine, as the population continues to age, and as the prevalence of chronic disease in the population increases, as a society we are going to have to make some very important social choices about the kinds of resources we want to devote to health care both at the governmental and personal levels. It is the family that provides the bulk of support and care to persons with chronic disease, particularly in the area of cancer care.

I don't particularly believe, and there is not an awful lot of evidence to suggest, that the breakdown of the family is really happening in America. However if it does in the future, important choices will have to be made about how care is provided, what support groups are necessary, and I think even more importantly, how the American people, the elderly and nonelderly, make choices about when to conceive of an illness as treatable and when to demand care and when to stop demanding care. At present we have very little information, I think, to adequately guide people in making their own decisions about that.

But I think what is really important is that in the future those decisions can be made and will be made by individuals and their families and not be imposed upon them, as in some kind of rationing.

Mrs. SCHNEIDER. One parting question that relates to the Federal level.

It is probably well recognized and perhaps better recognized in the last 5 years, our Federal research budget has gone through dramatic alterations in that our research budget for defense has grown exponentially.

Our research budget for a variety, or our nondefense, or our civilian area has decreased unbelievably. I would like for you to share with us a little bit of your insight as to what the future holds for the type of research grant that you are currently spending. And given the fact that Howard Swearer, the president of Brown University, serves with me on a board, the Business Higher Education

Forum, which is attempting to look for research moneys in the private sector and are finding that it is exceedingly challenging, I know that you are also involved in always trying to find moneys to do this kind of research. Your testimony has indicated the value of it, but where are we going to go to get this kind of information if the Federal Government is continuing to minimize your finances?

Dr. MOR. I would like to take this opportunity to make a plug. This current year's budget proposal has very strong cuts in two areas of research that are health services and health care related as opposed to basic science. These pertain to cuts in tne, budgets of the National Center for Health Service and Research and the Office of Research and Demonstrations of the Health Care Financing Administration.

Both of those agencies have traditionally taken a very strong role in trying to examine what are the factors in how people get care, what care they get, and what the effectiveness of that care is. It is very different than the National Institutes of Health to try to find out what are the causes of the disease and the basic biological functions of human and other animal systems.

I think in order to address questions like that of Congressman Lightfoot, we need to understand the epidemiology of health services utilization as much as we do the epidemiology and the process and origins of the disease.

So far as the likelihood of being able to draw upon the private sector to address those kinds of research questions, I think there are some possibilities.

With the aging of the population, and the advent of chronic disease, I would hope that insurance companies across the country will look to examine the feasibility of offering long-term care insurance for our population. In order to do that, they need to have a data base that makes it possible to make the actuarial projections so that they can run a business without going broke, offering an affordable benefit to the population. I think this approach would provide a great deal of security for people in the long run.

That is on the one side. On the other side, I would imagine that the health care industry, particularly the suppliers and producers of goods and services in the form of supplies and equipment which have been doing exceedingly well in the stock market of late and probably will continue to do so, might find—or the Government might find it to its advantage to have some kind of special surtax associated with that kind of revenue that would be funneled into a research fund.

Mrs. SCHNEIDER. So you would be supportive of the continuation of the research and development tax credit?

Dr. MOR. If they were directed, because at present, they are not directed and they are at the discretion of the individual company. Having dealt with the private sector on a lot of these issues, their fundamental interest is to sell the product while that of the independent researcher is to examine the particular research question. For instance, the Food and Drug Administration's fundamental issue is to, "protect the interests of the population." With the opposing interests of the various groups, I think it is important to have some independence and outside aspect of that.

Mrs. SCHNEIDER. Thank you.

No further questions.

Mr. BLAZ. Do we have time?

Mrs. SCHNEIDER. Yes, go right ahead.

Mr. BLAZ. The two answers you gave to my question earlier regarding the high incidence rate here in Rhode Island, one is the military effect. I never viewed Rhode Island as being one that is dominated by such.

Dr. MOR. It is not at present, but it was during the shipbuilding days.

Mr. BLAZ. When I was here, which now places me in the age group which is where I want to be right now. The second answer, however, you mentioned that the ethnic mix, because one of the things that struck me about the mix today, it is almost homogeneous as opposed to the heterogeneous mixture of people which is what I thought you alluded to. Would you care, if it is not embarrassing to you, to comment on that?

Dr. MOR. On the ethnic mixes? It is actually largely related, at least from what people have told me, to the prevalence people of Portuguese heritage who have different dietary habits. That is fundamentally what I meant in the issue of ethnic mixes.

Mr. BLAZ. Thank you. That takes care of my dilemma. Thank you.

Mrs. SCHNEIDER. Thank you very much for sharing some of your time and expertise with us, Dr. Mor.

Now I would like to call to the witness stand one of our earlier witnesses who was detained.

Rosemarie Lindgren is a homemaker from Saunderstown and I happened to meet Rosemarie years ago, about 1 year after my experience with Hodgkin's disease, and someone had called me and said, "Claudine, you seem to be doing all right. I think you ought to consult with a neighbor of ours because she seems to be having a problem," so that was my first opportunity to meet Rosemarie.

Welcome to you, and your testimony will be included in its entirety in the record, and feel free to share with us some of your thoughts about your experiences.

STATEMENT OF ROSEMARIE LINDGREN, HOMEMAKER, SAUNDERSTOWN, RI

Mrs. LINDGREN. Excuse me for my tardiness, coming on at quarter of four, when I should have been here at 1 o'clock. But one of my main problems is my memory—the tumor, which I had 9 years ago, was right in my memory center, and in order to prevent my having seizures, I take enormous amounts of medicine, and they put me in a very, very difficult times remembering things.

And I must write everything down. I always say: "Dr. Stoll, do you realize what you have done to me. I just can't remember a thing." He pats my arm and says, "Well, it is not all the tumor, it is a little of our age, isn't it?" He doesn't have any sympathy!

I think the main reason that Claudine asked me to be here, and I must say, I don't know that I would be here if it hadn't been for Claudine's constant encouragement, and you know, "Don't let anything get you down, Rosemarie, don't let anything get you down, you can get through the 7 weeks of radiation therapy every day,

except Saturday and Sunday. You will make it, you will get in there and you will beat it." And very fortunately, I did.

Dr. Mor's testimony was extremely interesting to me, and this relates to why Claudine wanted me to be here. I have said many, many times, it is amazing that in this little community of Saunderstown in which I live, so many people have had cancer.

It is a small village of about 200 families, and in the last 10 years, we had at least 18 folks of all ages, 2 young people, one a teenage, one 9-year-old, and the ages go all the way up from elderly people right into the thirties and the younger folks, and all types of cancer.

And speaking to the point of ethnic possibilities, it is mainly a WASP community. I hope that doesn't have anything to do with it. But we would certainly provide you with fertile evidence if you were interested in coming and seeing us. All types of cancer, all types.

Colorectal, many breast cancers. We lost our marvelous minister to leukemia. So it has run rampant and I, especially, am concerned because I have seven children, and if the statistics are right, I may lose one, at least, will possibly have to go through possibly something that I have gone through, and that I would do anything to prevent that.

If there is any way that we can get more research to look into it, anything that we in the community can do, I hope the Congress can hear us all, because this is the most, I think the most important thing right now that we all get on this.

The doctors are doing the research, they are telling us not to smoke, they are telling us to watch our diets, now we have got to listen and we have got to act on these things. I don't know what else to say.

Mrs. SCHNEIDER. OK, we can ask you some questions then.

Mrs. LINDGREN. Please do.

Mrs. SCHNEIDER. Could you share with us what you believe to be some of the most important contributing factors to your recovery? It has been what, 9 years now?

Mrs. LINDGREN. Nine years.

Mrs. SCHNEIDER. So, obviously, that has been a trying 9 years, but what do you think has been some of the contributing factors to keeping you healthy, alive, and well?

Mrs. LINDGREN. My community more than anything else. I fought, literally, I said to Dr. Stoll, "I will not take 7 weeks of radiation, that is all there is to it, I can't drag my husband out of work every day to bring me up here."

It is approximately an hour's trip from Saunderstown where I live, and I said, "He can't do that, it is impossible. I just will not do it." And he said, "You will do it and that is all there is to it." He left the room, came back later in the afternoon, and he said, "I spoke to one person in Saunderstown, a good friend of mine by the name of Marilyn England," and he said, "It is all arranged."

Within one afternoon, she had made up a schedule, talking to friends and neighbors. Every day, the radiation I dreaded most, a different friend pulled into the driveway, to pick me up. At 9 o'clock in the morning, brought me up, waited with me while I had my treatment, got back in the car.

If I was feeling well, we would go to lunch, or we would go to the art club, or we would go Christmas shopping, and then they would bring me right on back and plant me on my doorstep.

I couldn't get over it, I don't know how many times I said to Marilyn, this is unreal, that these people are so wonderful.

Never, though I was in the hospital quite awhile, did my husband have to make a meal. My children who were old enough that they could cook and care for their sisters and brothers, never had to make a meal. My neighbors delivered a hot meal at dinnertime every night. My husband couldn't get over it, and my mother-in-law said, "We could certainly take care of our own, Alan," and my husband said, "Mom, this isn't charity. This is love."

And when I came home I said to my good friends, I said, "You have been so wonderful." They said, "Oh, Rosemarie, you would do the same thing if it was you on the other side." And as it turns out, Dr. Stoll has sent me to see people who may be having a little trouble coping with it all, just as Claudine helped me, that I can stand up and say to them, you know, here I am, I made it. You can make it. But it is that support, that love, that faith that is, oh, that brings you through, that brings you through.

Mrs. SCHNEIDER. Congressman Blaz.

Mr. BLAZ. Rosemarie, I would like to ask a question, but I am not going to, because if I did, it would just delude the beauty of your testimony. I would just like to remember it as you have given it, so I am not going to ask you a question.

Mrs. LINDGREN. Oh, that is nice.

Mr. BLAZ. I just want to thank you for coming.

Mrs. LINDGREN. Nothing you could ask me would embarrass me.

Mr. BLAZ. I don't want to even take a chance that I might take away from what you just said. Now I know why I came.

Mr. LIGHTFOOT. I just echo Ben's comments, and Rosemarie, I think the good Lord had a good reason for you being the last one on the program today. Thank you very much.

Mrs. SCHNEIDER. I think that the comments that you have made, I was just making a few notes to myself to summarize your remarks, and I think the first thing was that when you told the doctor no way was I going to get this radiation, the first thing that came to my mind was to question authority, and I can't help but think that that is becoming more pervasive in the health care community.

I think that perhaps that is not all bad, that we need to question our doctors and ask information. It is also necessary for us to ask these questions of our pharmacists and of our health insurers, and I think as the consumer becomes more knowledgeable about how to shop around for good health care and appropriate treatment, we will be a healthier community.

The other comment that you made of what was so important was the support system and the love that surrounded you throughout this whole process, to help you through.

In our discussion of choices for a healthy life, which was the topic of this particular hearing, I hope that all of you have recognized that there are choices for a healthy life.

There are many different alternatives that we can pursue, and I think that during this entire hearing I had more people slipping

me little notes; one woman who was here, who happened to share with me she has had three cancer operations, Evelyn Long, who is 60-plus, she won't say what the plus means, but that is all right. We won't pursue it.

In 1965 she had a mastectomy and radiation treatment. In 1969 she had a mastectomy with no treatment. In 1979 she had a colon tumor and 1½ years of chemotherapy, and now she has no medication whatsoever and is strong and healthy and wearing bright lavender, which is a true health color, and we are happy to have you with us, Evelyn, and also happy that all of you were able to join us in our hearing today.

I might also say that one of the repeated comments that we got from our witnesses, particularly the cancer survivors, the importance of us spreading the word. When Rhode Islanders know the dismal statistics of cancer in the State of Rhode Island, I think it is twice as is important for us to share the positive information, to share the hope, to share the love and to communicate as much as possible that there are choices for healthy lives.

I hope that all of you have benefited from this hearing this afternoon, I hope that you will share with others the information that you have garnered here and I also, which is sort of out of character for a congressional hearing.

But I would like to very much thank the Providence Journal for being here, because we know that everyone is not able to attend these hearings because of work commitments or family commitments, but I think that this is a very important way to get the word out and we Members of Congress are working very hard to carry the information that we gathered here back to Washington and make sure that our Government is responsive to all of you.

Thank you very much.

[Whereupon, at 4 p.m., the hearing was adjourned.]

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